EMERGENCY CONTACT & MEDICAL FORM

Name: _____

DOB (YR/MO/DAY): ____/_____/_____

Address: _____

Phone: _____ Email: _____

EMERGENCY CONTACT PERSON	
Name:	Phone:

Mark With X

MEDICAL HISTORY	Yes	No
Has your doctor ever said that you should not participate in vigorous physical activity?		
Do you feel dizzy or chest pain at rest or during physical activity?		
Have you ever had a serious allergic reaction? Please list the allergy and any medication you have for this condition.		
Within the past 12 months have you had a bone or joint condition that could be made worse with physical activity?		
Have you ever been diagnosed with a chronic medical condition that may be aggravated by physical activity? Please list the chronic medical condition.		
Covid-19 Exposure Assessment		
Have you had close contact with anyone with a respiratory illness or confirmed case of COVID-19 without appropriate PPE?		
Have you had a fever, cough, unexplained fatigue/malaise within the last 14 days?		

Signature: _____ Date: _____

Course Name: _____ Location: _____

If your condition changes during the course, please advise the instructor immediately. Failure to disclose medical information could jeopardize individual or group safety.